Taking Forward Integrated Care in Australia: An International Perspective

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Understanding Integrated Care from a Global Perspective
A movement for change

Box 1: Four Commonly Used Definitions of Integrated Care

A health system-based definition
“Integrated health services: health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.” [4]

A managers’ definition
“The process that involves creating and maintaining, over time, a common structure between independent stakeholders – for the purpose of coordinating their interdependence in order to enable them to work together on a collective project” [5]

A social science-based definition
“Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people the outcome can be called ‘integrated care’” [adapted from 6]

A definition based on the perspective of the patient (person-centred coordinated care)
“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.” [7]
There are three distinct dimensions to what integrated care means in practice:

• Integrated care is necessary where fragmentations in care delivery mean that care has become so poorly co-ordinated around people’s needs that there is an adverse, or sub-optimal, impact on care experiences and outcomes.

• Integrated care therefore seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well coordinated around their needs. It is by definition, therefore, both ‘people-centred’ and ‘population-oriented’.

• The people’s perspective thus becomes the organising principle of service delivery, whether this be related to the individual patient, their carers/family, or the wider community to which they belong.
The ‘Hypothesis’ for Integrated Care

The hypothesis for integrated care is that it can contribute to meeting the “Quadruple Aim” goal in health systems:

- **Improving the user’s care experience** (e.g. satisfaction, confidence, trust)
- **Improving the health of people and populations** (e.g. morbidity, mortality, quality of life, reduced hospitalisations)
- **Improving the cost-effectiveness** of care systems (e.g. functional and technical efficiency)
- **Improving the work-life balance of care providers**
WHO Global Framework for Integrated People-Centred Health Services

WHO Global Framework

- Seeing people and communities as assets
- Empowerment, engagement and co-production
- Self-management
- Health education
- Focusing on the most disadvantaged

- New regulatory frameworks
- Aligning finances and resources
- Strengthening public reporting and involvement

- Rebalancing health services towards primary and community-based care
- Creating new methods of coordination and cooperation
- Defining team roles and responsibilities

- Active care co-ordination required, especially to those with highly intense needs
- Formal (‘real’) organizational integration not required
- Internal silos must be addressed
- Coordination at clinical and service level matters most
Competencies Necessary at the Project Level

Project INTEGRATE: Analysis of Context-Dependence

Using the Project INTEGRATE assessment tool we examined context-dependency in two ways:

- similarity/difference between contexts (e.g. type of client-base; type of care system)
- the connections between Framework dimensions (e.g. taking person-centred care as the outcome measure)

Positive scores on clinical integration (i.e. how care is co-ordinated around people’s needs) was the key factor associated with higher scores across the overall Framework when holding for context

- *This potentially corroborates other research findings that suggest it is integration at the clinical and service-level that matters most*

Positive scores in person-centred care (as the outcome) was correlated most closely with functional dimensions

- *This potentially corroborates other research findings that suggest that relational continuity – i.e. how information is shared and the way in which it is shared through good clinical integration – supports better system outcomes*

System-level factors seemed to be negatively associated with achieving person-centred care

- *This potentially corroborates that a focus on system reform and structures is NOT as important in achieving integrated care outcomes when compared to other aspects such as person-centredness, care co-ordination and functional integration*
Competencies Necessary at the System Level

The SCIROCCO Tool for Integrated Care

Self-assessment of maturity in care systems to support integrated care

Stakeholder perceptions and multi-disciplinary discussions

Identify strengths and weaknesses of regions to adopt integrated care

Facilitate improvements through transfer of knowledge, implementation support and ‘twinning’
Australia: A system with ‘low’ maturity to deliver an integrated care agenda

1. Readiness to Change
2. Structure & Governance
3. ICT & eHealth services
4. Standardisation & simplification
5. Funding
6. Removal of inhibitors
7. Population approach
8. Citizen empowerment
9. Evaluation methods
10. Breadth of ambition
11. Innovation management
12. Capacity building
Australia: A system with ‘low’ maturity to deliver an integrated care agenda

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Australia: A system with ‘low’ maturity to deliver an integrated care agenda

Basque Country
Spain, 2018

Scotland, 2018

https://www.scirocco-project.eu/
The Need for Integrated Care in Australia
Some Recent Reports

- Productivity Commission report *Shifting the Dial* (August 2017)
  - Proportion of years people living in ill-health as a percentage of life expectancy comparatively high
  - Care is episodic and driven by medical treatment in institutions
  - Care is not person-centred or co-ordinated – its fragmented, particularly between hospitals and primary / community care
  - Data collection ‘haphazard’
  - Significant scope to improve efficiencies, specifically in terms of health promotion and ill-health prevention
  - Funding siloes prevent collaborative action
  - Pilots rather than continuous service improvement
  - Activity-based funding does not encourage prevention/integration – need to look towards new funding arrangements e.g.
    - blended payments / pooled budgets in primary care;
    - regionally-based commissioning
Some Recent Reports

- CSIRO (2018) report *Future of Health: from illness treatment to health and wellbeing management*

Value should be rewarded over volume

1. Empowering consumers
2. Addressing health inequality
3. Unlocking the value of digitised data
4. Integrated care, underpinned by predictive analytics & new workforce skills
Developments at State Level

• e.g. NSW Health
  – Delivering integrated care is one of three strategic directions to help transform the health system
  – Focus is on reduced duplication of tasks, effectiveness of care transitions & pathways, improved health & wellbeing – empowered consumers, and workforce skills/capacity
  – Framework elements overall have good alignment with the global experience … but is it a reality on the ground?

International experience demonstrates tendency to ‘regress’ to managing acute sector demand and other traditional responses to financial pressures
Developments at Federal Level

- e.g. Health Care Homes Program (c.170+ operations)
  - Support better coordinated care for people with complex chronic conditions through a multi-disciplinary team
  - Promotes person-centred care, accessibility & coordination
  - Voluntary enrolment - bundled payments

Likely issues from the international experience
- Can have a very positive impact – but varied experiences in USA
- Focus on meeting funding/accreditation targets rather than focusing on improving care experiences
- Run in isolation – ability to integrate / align across sectors, especially with hospitals, will require a different funding arrangement & ability to pool budgets – beware ‘disintegrated integration’ syndrome
- Importance of place-based / community activities & local context
- Cream-skimming / equity / comprehensiveness – need to move to focus on population health
- Evaluate using a QI lens
Some Recent Reports

- **RACP (2019) model of *Chronic Conditions Management***

**Figure 2:** Model of Care for Cardiovascular-related Multi-morbidities (or more generically, multi-condition team care)

- Common funding
- Local control, service commissioning
- Local joint governance
- Use of health pathways
- Extend Health Care Homes style funding approach to all core members of the team
- The GP and consultant physicians will be paid a ‘salary’ per patient, not on an activity or per episode basis
- The team physician is the main liaison point for other physician services
- Improved communication between the team, especially physicians and GPs including non patient based
- Proof of concept sites to be developed

**Essential component**: complete transitioning of patient and their relevant information to next lead clinician involved and follow-up communication.
Where is the Evidence?
### Review of reviews of integrated care

**Table 4** Results of 27 systematic reviews of integrated care for different conditions and outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of reviews with improved outcome/no. of reviews assessing outcome^a</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CHF (12 reviews)</td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td></td>
</tr>
<tr>
<td>Improved glycaemic control</td>
<td>4/7</td>
</tr>
<tr>
<td>Improved blood pressure control</td>
<td>1/4</td>
</tr>
<tr>
<td>Reduced mortality</td>
<td>5/8</td>
</tr>
<tr>
<td><strong>Functional</strong></td>
<td></td>
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<tr>
<td>Improved exercise capacity/function^b</td>
<td>2/2</td>
</tr>
<tr>
<td><strong>Patient centred</strong></td>
<td></td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>4/8</td>
</tr>
<tr>
<td>Higher patient satisfaction</td>
<td>0/2</td>
</tr>
<tr>
<td><strong>Process of care</strong></td>
<td></td>
</tr>
<tr>
<td>Improved adherence to treatment guidelines^c</td>
<td>2/5</td>
</tr>
<tr>
<td>More regular retinal and foot examinations</td>
<td>3/7</td>
</tr>
<tr>
<td><strong>Use of healthcare resources</strong></td>
<td></td>
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<tr>
<td>Reduced hospital admissions</td>
<td>4/6</td>
</tr>
<tr>
<td>Reduced readmissions</td>
<td>5/9</td>
</tr>
<tr>
<td>Reduced re-admissions or mortality</td>
<td>2/2</td>
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<tr>
<td>Increased time between discharge and readmission</td>
<td>1/3</td>
</tr>
<tr>
<td>Reduced length of hospital stay</td>
<td>4/8</td>
</tr>
<tr>
<td>Reduced number of ED visits</td>
<td>2/3</td>
</tr>
<tr>
<td>Increased use of appropriate medication</td>
<td>0/2</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Reduced costs of services</td>
<td>1/8</td>
</tr>
</tbody>
</table>

Source: Martínez-González et al. (2014)
### Review of reviews of ‘integrated care programmes’

<table>
<thead>
<tr>
<th>Studies with only descriptive analyses</th>
<th>Hospitalization</th>
<th>Mortality</th>
<th>Process outcomes&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Functional status and health outcomes</th>
<th>Patient satisfaction</th>
<th>Quality of life</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferguson, 1998 [21]</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
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<tr>
<td>Moser 2000 [10]</td>
<td>−</td>
<td>−</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
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<tr>
<td>Studies with also meta-analyses</td>
<td></td>
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<tr>
<td>McAlister 2001 [17]</td>
<td>¬*</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
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<tr>
<td>McAlister 2001 [9]</td>
<td>¬*</td>
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<td>+</td>
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<td>−</td>
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<tr>
<td>SUTC 2001 [18]</td>
<td>¬*</td>
<td>?</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<td>Weingarten 2002 [20]</td>
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<td>+</td>
<td>+</td>
<td>+</td>
<td>−</td>
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</tbody>
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<sup>1</sup> Process outcomes as for example provider monitoring, compliance and adherence to guidelines.

? = effect remains unclear; − = trend shows decrease (in more than half of the included studies); + = trend shows increase (in more than half of the included studies); * = trend is significant.
# The impact of care coordination

<table>
<thead>
<tr>
<th>Main focus of intervention (number of studies)</th>
<th>Proportion (%) of studies with positive outcome for</th>
<th></th>
</tr>
</thead>
</table>
| **Changed relationships between service providers**  
  e.g. co-location, case management, multi-disciplinary teams (33) | Health: 19/29 (65.5%)  
  Service user satisfaction: 8/12 (66.7%)  
  Cost saving: 2/12 (16.7%) |  |
| **Coordination of clinical activities**  
  e.g. joint consultations, shared assessments and priority access to another clinical service (37) | Health: 19/31 (61.3%)  
  Service user satisfaction: 4/12 (33.3%)  
  Cost saving: 3/15 (20%) |  |
| **Improving communication between service providers**  
  e.g. case conferences (56) | Health: 26/47 (55.3%)  
  Service user satisfaction: 12/22 (54.5%)  
  Cost saving: 2/21 (14.3%) |  |
| **Support for clinicians**  
  e.g. support or supervision for clinicians, training (joint or relating to collaboration), reminder systems (33) | Health: 16/28 (57.1%)  
  Service user satisfaction: 8/14 (57.1%)  
  Cost saving: 1/12 (8.3%) |  |
| **Information systems to support co-ordination**  
  e.g. care plans; decision support; user held/ shared records; shared information systems; service user register (47) | Health: 23/38 (60.5%)  
  Service user satisfaction: 7/19 (36.8%)  
  Cost saving: 2/13 (15.4%) |  |
| **Support for health/social care service users**  
  e.g. education, reminders; assistance in accessing care (19) | Health: 6/17 (35.3%)  
  Service user satisfaction: 3/6 (50.0%)  
  Cost saving: 1/7 (14.3%) |  |
| **All studies** | Health: 36/65 (55.4%)  
  Service user satisfaction: 14/31 (45.2%)  
  Cost saving: 5/28 (17.9%) |  |

Source: Powell Davies et al. 2008
The emerging picture on evidence: Integrated Care’s *Achilles Heel*?

1. We know that integrated care where it helps to co-ordinate care around the needs of people at a personal, clinical and service-level can improve quality of care, care outcomes and care experiences.
2. Uncertainty remains on the relative effectiveness of different system-level (organisational) approaches to integrated care as new structural solutions are often observed to be costly.
3. Getting the design and implementation of IC programmes right is important, and requires time to innovate and mature.
4. Research studies look at integration, not integrated care!!!
   - The transformational impact of integrated care is at the micro-level of the patient, service user and professional teams, yet evaluation often fails to examine how care is actually delivered.
5. There is a lack of robust evidence overall on the economic impacts of integrated care approaches, but a significant amount of positive context-specific case experiences.
Programme evaluations have shown limited ability to explain their results, so making it problematic to judge impact and costs.

Process evaluations provide explanation of key variables that influence the design and delivery of integrated care programmes, but don’t give an understanding of what works, when and where?

There is a need for a more intimate relationship between research and practice in order to understand its complexities and the strategies that result for effective implementation.
A Scaling-up of Ambition Towards Place-Based Solutions
Case 1: Co-ordinated Care Organizations in Oregon

Since 2012, Oregon Health sought to rebuild its Medicaid programme around community health rather than individual fee-for-service treatments for its 600,000 Medicaid beneficiaries. They struck a deal with the Obama government following the Affordable Care Act to gain a $1.9 billion transformation fund on the basis they could ‘save’ $11 billion over ten years (compared to projected figures on spend).

They created 16 ‘co-ordinated care organisations’, different to ACOs as they took responsibility for community health – e.g. prevention agenda and socio-determinants.

Oregon Health Authority’s performance programme held back 3% of payments into a ‘quality pool’ that CCOs could access if they met 12+ of 17 quality measures and have 60% of their members enrolled in a patient-centred medical home.
Case 1: Co-ordinated Care Organizations in Oregon

Health Management Associates’ Annual Projected Savings Attributable to Health System Transformation through Coordinated Care Organizations

A movement for change

Case 1: Co-ordinated Care Organizations in Oregon

How it works

➢ Network of all types of health care providers in 15 geographic communities across Oregon with a single capitated budget
➢ Shared accountability - governance to local community and payer
➢ Development of new model of care based on PCMH-model
  ✓ Inter-disciplinary teams – health care homes
  ✓ Care transitions (hospital to home)
  ✓ Intensive transitions (mental health)
  ✓ ED navigators
  ✓ ICT investment

Impact in 2015 based on 2011 baseline

➢ Reduced ED visits in CCOs by 22%
➢ Reduced hospitalisations due to diabetes (26.9%) and COPD (60%)
➢ Increased enrolment in health care homes by 56%
➢ Oregon CCO experiment results, however, uneven – has faced significant implementation challenges
Case 2: Basque Country, Spain

Integrated Care Organizations (OSIs)

From a pilot programme in Bidasoa, all regions in the Basque Country moved to OSIs in 2015 – covering 2.2 million people.
Case 2: Basque Country, Spain

Integrated Care Organizations

➢ The implementation of care pathways and protocols for key chronic diseases such as COPD and diabetes
➢ Advanced nurse practitioners to manage people with multi-morbidity in the community
➢ Hospitals unified with their primary and community care colleagues through integrated health organisations (OSIs)
➢ Growing networks with social care
➢ The OSIs work to a single strategic plan with unified governance and incentives.

Impact (in Bidasoa pilot): better experience of care in terms of patients’ perceptions of care coordination; a reduction in hospital utilisation, particularly for patients with complex chronic conditions; and cost-containment in terms of per capita expenditure.
Case 3: Millom, Cumbria & Morecambe Bay, UK

Millom Alliance founded in rural community of 8500 people in response to closure of community hospital and crisis in GP recruitment – assets-based approach embraced

2014

Whole of Cumbria & Morecambe Bay (750k people) supported through 20 community-based alliances – fastest transforming integrated care system in the UK enabling 8-10% year on year financial savings & turnaround in population health outcomes

“Working as equal partners with the community resulted in improvements for healthcare locally highlighting the importance of co-creation”
The Integrated Care Equation

Integrated health and social care teams (building real teams around place and pathways)

Activated Individuals, carers and families (activated individuals use services less and have better outcomes)

Communities mobilised at scale for health and well being (the community as part of the local leadership and delivery team)

Changed drivers in the health system (system leadership, system architecture, system culture, changed drivers, impacting on commissioning and provision)

=A population health and wellbeing system
Key Priorities for Integrated Care in Australia
Integrated Care in Australia
Eleven Priorities for Action

1. **Provide a compelling narrative** for integrated care
2. **Population health focus** – integrated thinking on key strategies such as public health, mental health, ageing, children and families – this has the biggest potential for transformational change
3. **Engage with the community** through co-productive partnerships that empower and promote person-centred care
4. **Devolution** - take a place-based approach that centres activities on a regional and local basis (key role for LHNs, PHNs, Councils etc)
5. **Align financial incentives** & move towards pooled budgets and capitation-style contracts - providers to take on financial risks / gain financial rewards
6. **Allow innovations** in integrated care to embed
7. Move from micro-purchasing with a short-term competitive tendering mindset to **strategic commissioning** that develops new types of alliances and contracts for long-term gain
8. Develop **new systems of governance and accountability** that support integrated care – towards alliances and integrated care systems
9. **Support programmes** for leadership, organisational development, quality improvement, and coaching to support implementation
10. **Invest in workforce skills and capacity** – especially in primary and community care settings, and across physical/mental health care
11. **Evaluate the impact of integrated care** – focus on value created rather than efficiencies gained – avoid trials mentality - share innovation and learning – focus on implementation science and quality improvement
Designing and Implementing Integrated Care

An Accelerated Learning Course for Leaders in Integrated Care Programs in Australia

Centre for Rural and Remote Mental Health, University of Newcastle, Orange, New South Wales
Mon 4 Nov – Fri 8 Nov 2019

Upcoming Events of IFIC Australia

2nd Asia Pacific Conference on Integrated Care
11-13 November 2019
Melbourne, Australia

Achieving better value for people and populations
Want to know more?

https://integratedcarefoundation.org/ific-australia

Email: ificaustralia@integratedcarefoundation.org
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